Head Injury Flowchart

Ondansetron should not be given to children with head injury without ED Consultant approval

Mild Head Injury

- AVPU = A
- GCS = 14-15
- No LOC
- Disorientation
- ≤ 1 vomit
- Normal neurology
- No physical evidence of skull fracture

- Observe for 2-4 hours post injury

Symptomatic — **Yes** → Admit to ED Observation Ward

No

Discharge home with **Head Injury Health Fact Sheet**

Moderate Head injury

- AVPU = AV
- Brief LOC
- Drowsy
- ≥ 2 vomits
- Normal neurology
- Brief seizure after head injury
- Large scalp bruise or laceration
- Amnesia of event

- Admit to ED Observation Ward
- Neurological observations hourly
- Refer to ED Guideline: **Criteria Led Discharge**
- Consider CT (see Head Injury Guideline

Severe Head Injury

- AVPU = PU
- LOC ≥ 5 mins
- Seizures
- Focal neurological deficit
- Penetrating head injury
- Signs of raised intracranial pressure

- To resuscitation room
- Assess and manage ABC
- Initiate c-spine precautions

- Intubate and ventilate to protect airway
- ETCO2 should be maintained at 35-45mmHg
- Hyperventilation should be reserved for children with signs of raised ICP
- Insert oro gastric tube
- Urgent CT scan
- PICU consult

Skull X-Rays

- Rarely required but should be considered in < 1 year olds who have a boggy or depressed area

Intracranial Pressure

- 1mL/kg IV of 20% saline slow push

OR

- 0.5-1g/kg IV Mannitol
- Insert urinary catheter
- Plus
- Head position should be kept midline and the bed elevated to 30° degrees

Anti Seizure Prophylaxis

- **Phenytoin** 20mg/kg over 20 minutes
- Seizures are common with severe traumatic brain injury. Particularly in the first 24 hours.

We take no responsibility for the use of these guidelines outside of our institution. Please read our disclaimer.